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# Palliative Care Ethics: Medicine's Duty to Help

*Sukru Keles*

## Abstract

In palliative care, death, which is a part of human nature, is considered as a normal process. This type of care is concerned with the quality of life rather than its duration. In this context, the basic aim is to perform practices to relieve the patient in a way that does not raise any ethical suspicion. Within this framework, it can be said that palliative care is a requirement of medicine's duty to help. The aim of this chapter is to draw attention to the importance of ethical values in the configuration of palliative care services for patients who are in the last period of their life or the ones who have terminal illnesses. In palliative care, it is essential to arrange care services in a manner that does not raise any ethical doubt about the measures taken to increase beneficence both to the patients who are in the last days of their life and to their relatives. In this study, "The Directive for Implementing Procedures of Palliative Care Services" prepared by the Ministry of Health in Turkey in 2015 will be evaluated in terms of ethics.

**Keywords:** bioethics, medical ethics, clinical ethics, palliative care ethics, directive

## 1. Introduction

Ethics is a branch of medicine that deals with the questions as to the values such as "What's good" or "What's good for people" [1]. Medical ethics is a branch of general ethics which centers on moral issues encountered in the field of health. In this respect, medical ethics is a field where the emerging moral issues, particularly the ones stemming from the medical advances witnessed in the twenty-first century in diagnosis and treatment tools, are discussed.

In health ethics, studies on the evaluation of moral priorities in the field of health and in legal, political, or institutional aspects and the analysis of their possible outcomes have been carried out. Different from medical ethics, health ethics deal with issues that concern a larger majority of the society. Ethical evaluation of health decisions made on a societal level and in accordance with the regulated norms, policies at hand, and supported projects is one of the topics of interests in health ethics.

The right to a healthy life is a fundamental human right. Everyone has the right to receive healthcare, and this right is guaranteed by the constitutions of nations. The right to healthcare is a positive right. Therefore, healthcare providers are expected to create opportunities for the beneficiaries. Besides, configuration of different kinds of health services in healthcare is essential.

There is a close relation between health ethics and the legal regulations for maintaining healthcare services. The significant point in terms of health ethics

is that the legal regulations are drawn in an ethically acceptable manner. In this respect, “The Directive for Implementing Procedures of Palliative Care Services” prepared by the Ministry of Health in Turkey in 2015 will be evaluated in terms of ethics in the subsequent sections of the study [2]. With that directive, it was aimed to provide medical, psychological, social, and moral support to both patients and their relatives when life-threatening diseases are at stake. It can be said that the Directive, which comprises basic ethical principles and their extensions, satisfies the expectations of patients and their relatives from palliative care services to a large extent [3].

Given that the organization of palliative care services across the country is a recent trend, it can be envisaged that palliative care will be accepted by healthcare demanders as an accessible and claimable healthcare service in the forthcoming years.

## **2. Palliative care and “confidence” in medicine**

In the literature of medical ethics and philosophy, the necessity to perform certain actions or deeming them as necessary is considered to be a “duty” [1]. The duty of a healthcare professional or a physician is based on carrying out an action that she/he is authorized or allowed to do in an appropriate manner. In established philosophical thinking, at least from Kantian thinking to modern philosophy, the concept of duty in ethics means acting from intention without any compulsion and believing that it is the right thing. As a requirement of social contract, the sense of duty forms the basis of behaving ethically. In this respect, regardless of any legal and juridical imposition, healthcare professionals feel themselves responsible for the practices they perform and act accordingly and provide healthcare services to patients. It is imperative that healthcare professionals carry out their duties in accordance with the medicine’s *raison d’être* in order to maintain the confidence in medicine.

Healthcare professionals are expected to care for patients and be sensitive to their needs. The thing to consider here is paying regard to beneficence to the patient and helping the patient improve his/her current condition. A relationship based on trust between the healthcare professional and the patient or the patient’s relatives is a prerequisite to pursue the implementation of healthcare services at the optimum level. Providing healthcare services to anyone who requests it is one of the most fundamental duties of healthcare professionals.

Palliative care is not centered solely on patients; it also covers the practices such as fulfilling the needs of patients’ relatives as well. This includes helping the patient’s relatives in the mourning days, after the loss of the patient. Palliative care service is carried out by a team, and each step of the process is accompanied by healthcare professionals qualified in their field.

The World Health Organization (WHO) defines palliative care as follows:

“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” [4].

The emerging points in the definition of the WHO are:

- i. Palliative care ethics focuses on moral problems related with the end of life.
- ii. Patient care shall not be defined just with medical procedures; social, cultural, economic, and belief systems are also the important components.

- iii. Human is a creature who must be respected; therefore, the quality of death should be equally esteemed as the quality of life.

In societies where the philosophy of palliative care is not fully comprehended, such care practices are frequently confused with other practices. It should be noted that palliative care is not:

- i. Letting the patient to die
- ii. Assisting the patient to die
- iii. Speeding up the patient's death
- iv. Sustaining the life in an artificial manner

The quality of palliative care is closely related to “confidence” in medicine. In order to provide palliative care to a patient in the last days of his/her life, it's imperative that the patient demands this care at his/her own request and approves of it. The patient should be informed about the purpose of palliative care and the possible benefits of it. It is crucial that the patient has competence to give such a decision and approve of the procedure. Within the context of medical ethics, competence means an individual's ability to make autonomous decisions concerning his/her own health [1]. When a competent individual whose life is coming to an end loses his/her competence, he/she must have unconditional confidence in medicine as to what kind of healthcare he/she will receive. It is disputable how to act in conditions where competence is lost due to the cultural values in different societies. Therefore, the most ethically appropriate act would be taking into account the decision that the patient made when he/she was still competent and assuring the patient in this regard when she/he had competence.

### **3. Palliative care and the patient's “compelling” medical condition**

Recently, a number of opinions have been generated as to the fact that care services to be provided for life-threatening diseases shall not be limited to medical theories and practices and that the related culture, economy, society, and political environment must also be taken into account [5, 6]. In palliative care, life-threatening diseases are needed to be handled with a holistic approach, and for this reason, a care service performed by a multidisciplinary team is offered to patients and their relatives. In palliative care, ethical values specific to this “challenging” period are emphasized, and suggestions for resolving ethical problems are debated [7, 8].

Contemporary palliative care began at the end of the 1950s by means of observing dying patients and providing healthcare services to them. Dr. Cicely Saunders observed dying patients and stated that an interdisciplinary team could be able to alleviate the pain of dying patients and their relatives. Today, providing end-of-life care with a team of healthcare professionals constitutes the core of palliative care services. Dr. Elisabeth Kübler-Ross, who was a psychiatrist in the USA in the 1960s, emphasized in her book *On Death and Dying* the importance of open, respectful, and honest communication with dying patients. In 1974, Dr. Balfour Mount pointed out the importance of a holistic approach in respect of physical, mental, and social aspects to patients who have life-limiting illnesses and their families. In 1997, with the report “Approaching Death: Improving Care at the End of Life,” the Institute of Medicine documented the shortcomings related with the end-of-life care and paved

the way for a growing interest in palliative care in medical practices. In addition, “Clinical Practice Guidelines for Quality Palliative Care” was published in 2004, and since then palliative care services have been offered to not only dying patients but also the ones with life-limiting diseases [9].

Today, palliative care is given to patients from various age groups and for different illnesses. The difficult conditions in which the dying patients or patients with chronic diseases and their relatives go through might cause health professionals to feel themselves desperate in providing healthcare to them, just like a family mourning for their child would feel [10]. It was reported that when the risk of losing a family member emerges, it influences all members negatively [11]. A previous study emphasized the importance of giving the families reliable and comprehensible information during those challenging times. In that study, it was also pointed out that the technical information which medicine offers is not sufficient and must be reinforced with emotional care, which is also an important aspect [12]. In addition, it was emphasized that communication skills and ethical professional values still constitute the essence of medical practices despite the increasing use of advanced technologies and increased information in the field of health [13]. Paying regard to the humanistic side of medicine in the delivery of palliative care services to patients and their relatives is possible only when health professionals develop an ethical sensibility and have ethical conscience.

Hospices constitute an alternative to hospital-centered care. The purpose of hospice care is to provide an effective pain treatment in order to bring symptoms such as nausea, vomiting, diarrhea, and weight loss under control and to relieve the patient through nutritional and ventilatory support. It is different from conventional hospitals in that its priority is, within the bounds of resources available, to help dying patients and their relatives before their lives come to an end. These days, the interest in hospices is increasing due to the aging population, and this brings about ethical problems. The most notable ones among the problems encountered in hospices include upholding resident autonomy, managing family distress, lack of staff communication, and lack of time [14]. It is clear that providing healthcare services in hospices with an approach that pays regard to the values of patients and their relatives will increase the confidence in these newly developed health centers.

#### **4. Proliferation of palliative care practices in Turkey**

According to Tanrıverdi and Kömürcü, studies on structuring palliative care services in Turkey started with the initiatives of the Society of Algology, which was founded by Dr. Serdar Erdine, an anesthesiologist and reanimation specialist, in 1998, and the early studies carried out on pain palliation [15]. In the same period, medical oncologist Dr. Şeref Kömürcü studied the concept of palliative care in oncology. Following these initiatives, “Supportive Treatments Study Group” was established in 1999 within the body of the Turkish Society of Oncology Group. The Cancer Dispensary, which was established in Turkey by Turkish Oncology Foundation and actively served between the years 1993 and 1997, is considered to be the first institution that is close to the concept of hospice where palliative care services are offered [16, 17]. This was followed by the establishment of Ankara House in 2006 by Hacettepe University Cancer Institute. The Ankara House, also referred to as “Hacettepe House of Hope” is a hospice that offers palliative care services and treatment and accommodation to cancer patients for a certain period of time. However, the House could not actively serve for a long time.

One of the reasons why proliferation of hospices in Turkey is a more recent process than in Western countries is believed to be the prevailing negative perceptions of



the society on the concept of retirement home for old people, which has become a privatized healthcare service for the last decades [17]. In today's world, proliferation and improving the quality of healthcare institutions such as home care services, retirement homes, and nursing and rehabilitation centers for old persons reinforce the confidence in social aid and social service works.

Palliative care services have become more widespread through the project "Palya-Turk" conducted by the Cancer Control Department of the Ministry of Health. Nevertheless, when the existing need for palliative care in Turkey is considered, it can be said that the current palliative care services fail to fully meet this need [18]. Besides, it has been pointed out that the palliative care provided in Turkey for patients with chronic diseases or the ones close to the end of life is perceived as a care service offered only to cancer patients [19]. However, it is acknowledged that the primary issues to be dealt with are building a trust relationship between health professionals and patients and their relatives, enabling active participation of patients and their families to decision-making processes and improving the patients' quality of life by means of avoiding futile treatments [20]. Today, palliative care services are provided, though on a limited level, either at home or at health institutions depending on the type of illness.

#### **4.1 The palliative care directive in Turkey and the emerging ethical values**

"The Directive for Implementing Procedures of Palliative Care Services," which regulates the minimum standards of palliative care centers founded within the body of inpatient health institutions, was put into effect with the regulatory dated June 07, 2015 and numbered 253 [2].

In these centers, patients can receive various healthcare services including physical examination, medical work-up, analysis, treatment, medical care and rehabilitation services, psychosocial support, psychosocial evaluation (distress, anxiety, depression, hope, loss, mourning, grief, and self-care), pain management (opioid use), nutritional support, and so on. In addition, the centers can also issue medical reports as to a patient's need for medication, medical devices, and medical equipment.

The abovementioned Directive constitutes the framework for delivery of palliative care in Turkey. The backbone of the Directive is to improve patients' and their relatives' quality of life in order to alleviate or prevent their pain and suffering [3].

##### **First section**

##### **Objective, Scope, Basis and Definitions**

*Article 1—"The objective of this Directive is to enable early identification and assessment of pain and other symptoms of patients occurring due to life-threatening illnesses, to alleviate or prevent pain by providing medical, psychological, social and moral support to these persons and their family members, to establish palliative care centers with the aim of improving their quality of life, and to determine the rules and procedures as to these centers' operation, physical conditions, minimum standards for equipment and personnel, duties and responsibilities of the personnel, and supervision of their practices."*

**Quality of life:** some of the opportunities that modern medicine offers contribute to lengthening life-span. Palliative care aims to increase the quality of life. The meaning content of the quality of life is one of the topics that are being discussed by moralists and philosophers [21]. Also, one of the questions that awaits answering

in terms of ethics is what gives value to human life. In this respect, the value of life is considered together with the quality of life. Improving the patient's physical and emotional well-being within the bounds of possibility in order to improve the quality of life is one of the *raison d'être* of palliative care. In this way, it is aimed that the patient shall continue his life, make choices, and maintain communication with his environment as much as possible.

A person's life is important not only to himself but also to his family members, friends, acquaintances, and other people with whom he/she has an emotional relationship. Therefore, in palliative care, the cordial relationship that the patient establishes with his/her relatives and the well-being of the individuals apart from the patient are also taken into consideration. In this respect, one of the most important constituents of the Directive is that it enables patients to spend time with their relatives in an appropriate environment.

Besides, the Directive also aims to standardize the centers that provide palliative care in order to improve the life quality of the patients struggling with life-threatening diseases. This has stemmed from the intention to help structuring healthcare services in a sense that they are accessible and claimable and to bring a common perspective to the palliative care philosophy.

## Second section

Establishment of centers, physical conditions and minimum standards for equipment, provision of transportation vehicles

*Article 5—(1) “Palliative care services are provided at palliative care centers in inpatient care institutions, home care service units outside those institutions, and family practice centers. Inpatient care institutions can make a protocol with care centers for giving palliative care to the ones staying there and provide palliative care service on condition that it is ratified by the Directorate.”*

**Proliferation of palliative care:** palliative care services are provided in various types of health institutions in order to make it a more widespread and common practice. Palliative care centers in Turkey are organized as (i) “primary level” palliative care centers that encompass palliative care units at family practice centers and hospitals, (ii) “secondary level” that includes palliative care centers (acute care), and (iii) “tertiary level” which covers comprehensive palliative care centers (acute care) and hospices (chronic care) [22]. In this way, a patient can benefit from a variety of palliative care units that best suit their needs.

*Article 6—(1) “The number of beds at a palliative care center to be established within the body of a health institution shall not exceed 25% of the total number of beds for a hospital with 100 or less beds, 20% for a hospital with 101-300 beds, 17% for a hospital with 301-500 beds, and 15% for a hospital with 501 or more beds.”*

**A fair resource allocation:** the fact that the minimum number of beds in hospitals to be used for palliative care has been determined through the Directive brings up the issue about how to share the limited resources in an ethically appropriate manner. The question as to which criteria should be taken into account while evaluating the patients requesting this care is ethically disputable because different point of views on allocation of limited resources may lead to different practices. In this respect, subjective considerations can also be evaluated such as the patient's medical condition, prognosis of the illness, the amount of time that the patient need palliative care, and the beneficence of palliative care to the patient and his/her relatives. In the Directive,

there is no information about how to allocate beds among patients. However, this could be a deliberate preference because it might have been deemed inappropriate to determine the selection of patients to benefit from this care with the Directive since it is a patient-specific process confined to the patient's unique conditions.

In addition, receiving consultancy service from ethical committees for accepting patients to the centers with limited patient admission capacity should be fostered since this will save the responsible physicians from making the decision alone.

*Article 6—(2) “Procedure and Examination Rooms are the places equipped with appropriate medical equipment and devices where physicians can intervene to their patients and where family negotiations and services such as psychological and social services shall be provided. When necessary, an appropriate number of procedure and examination rooms can be designated. Occupational Room is an optional facility where patients receive physical therapy, occupational therapy, speech and language therapy, treatments and services to relieve them physically and psychologically, and where family negotiations and psychosocial services are provided.”*

**Privacy:** the presence of special areas in which the healthcare staff who provide palliative care services deal with the needs of the patients and their relatives is an indicator of respect for their private lives. In addition, the presence of occupational rooms might help reduce the challenging factors that patients and their relatives encounter during this period. The presence of unwanted people during an intervention or examination might violate privacy. In this context, paying regard to the necessary spatial arrangements for the provision of a humanly end-of-life care to the patient and for the protection of the patient's relatives from being disturbed can be considered as an indicator of ethical sensibility.

All kinds of information that the physician get in patient-physician relationship is dealt within the scope of professional confidentiality [23]. In this respect, the Directive could also entail that physicians shall not reveal patients' secrets or confidential information that they obtain from the encounters with patients. It is acknowledged that this liability of the physician should continue after the patient's death or termination of the patient-physician relationship.

The Directive can be given as an example to the practices that reduce the patient load of the intensive care units where life-supporting treatments are performed and to the places where procedure and examination rooms are prepared for patients requesting palliative care when needed. Such practices can facilitate the access to treatment needs of other patients in the hospitals. In the literature, it was argued that when the patients requiring palliative care occupy beds in hospitals for a long time, it reduces the efficiency of the facilities offered in those hospitals [24].

*Article 7—(1-2) “Transportation and transfer vehicles allocated for health institutions and directorates that offer home care services can be used by the centers as well if necessary. (...) In case of emergency, patients shall be transferred via the ambulances of health institutions or 112 emergency services.”*

**Patient transfer:** it is possible that patients might get harmed during their transfer to healthcare centers or to another city. In the Directive, it was stated that patients' transfer might be assisted if necessary and that it is tried to prevent the damages to occur due to the transfer process. The attempt to avoid any risks toward a patient before they emerge reflects the existence of a sensibility in line with the medicine's ethical principle of non-maleficence.



### Third section

Personnel assignment and minimum personnel standards, duty, authority and responsibilities

*Article 8—(1-5) “(...) The services at the center shall be performed under the responsibility of the physician in charge along with the other personnel including physicians, nurses, medical secretary, administrative and technical staff, cleaning staff and so on. (...) There’s no obligation to recruit a full-time psychologist, social worker, physical therapist or physical therapy technician, and dietician at the center; but if any need emerges, it shall be met by the hospital’s own staff or from external sources. (...) Necessary training of the staff recruited for palliative care services in the centers shall be provided by the Administrator.”*

**Duty of education:** in palliative care, the responsibility of identifying and solving the problems of patients and their relatives is expected primarily from those who provide that service at the outset. Allowing patients and their relatives to express themselves and facilitating communication might prevent any harm that may occur to them to a large extent. Therefore, along with their residency training in palliative care, it is also important to offer education on basic ethical knowledge, including trainings on communication skills and problem-solving methods for persons who provide palliative care services.

The trainings given to healthcare professionals in order to improve the quality of service should also cover the issue of identifying the ethical problems faced in palliative care. Therefore, training of the staff that is in charge of providing palliative care for patients with chronic diseases or the ones close to the end of life could eliminate the mistakes to be made out of ignorance. However, it is crucial to reinforce ethical knowledge education since it puts healthcare professionals who have benefited from this training in a situation where they confront their own values. It is obvious that provision of ethical education for those who provide palliative care services will contribute to building the ethical standards in palliative care.

### Fourth section

Working Principles and the Scope of Service

*Article 11—(1-4) “The centers assess the palliative care provided to patients and family members as a whole and take all kinds of necessary precautions with a team mentality in order to ensure that they get the most out of the service. (...) Under the coordination of Provincial Directorate of Health, the centers aim to raise public awareness on palliative care by means of collaborating with local governments, other health institutions in the region, universities and other related organizations, and if necessary, visual and print media.”*

**Biopsychosocial model:** being aware that the patients and their relatives have their own universe of values shall increase the quality of the palliative care services offered. Therefore, it should be accepted that patients and their relatives have different health needs. Being aware of the values and belief systems of the patients and their relatives; assessing each patient as a whole in respect of physical, psychological, and social aspects; and taking precautions accordingly are the conducts all of which should be supported ethically.

**Ethics of health education:** during monitoring and observation processes, healthcare professionals working at the centers contribute to improving the patients', their relatives', and, indirectly, the society's health. The healthcare professional responsible for training and preserving the holistic approach of the profession plays an active role in patients' and their relatives' decision-making processes through active participation. Health educators carrying out works on raising people's awareness must consider the differences in the structure of society as a value and act accordingly.

### Fifth section

#### Application for Palliative Care Services, Patient Admission, Transfer and Transportation Principles

*Article 13—(1) “Applications shall be made in person by the patients themselves or by their family members, or they shall be directed to the center or the healthcare provider who provides palliative care services after necessary consultation and coordination has been made during the patient's discharge by means of maintaining necessary negotiation and coordination with the curative doctor or family practitioner who is in charge of the patient's follow-up and treatment. Through a visit by a health team, the patients who are unable to come to a health facility shall be assessed in their home environment as a whole, along with the family members that they live together. As a result of the assessment, the patients found eligible to receive palliative care service shall be referred to the centers.”*

**Paternalism:** in palliative care, it may be on the carpet that, for the sake of protecting their patients fighting against life-threatening diseases or to relieve their distresses, the physicians in charge might adopt a paternalistic approach based on their sensibility they have developed for the individuals in this group. However, in contemporary way of ethical thinking, it is ethically troubling for a physician to make decisions in lieu of the patient without any reasonable ground. Therefore, interventions made without the consent of the patients or their relatives might be interpreted as violation of personal rights.

Seeing the patient and the patient's relatives by the responsible physician both in the palliative care center and in the patient's house has several advantages. Encouraging the patient to make an autonomous decision and listening to the patients and their relatives without governing them are ethically appropriate attitudes and behaviors.

**Time:** in palliative care, “time” is a special component of limited resources. Beginning to provide palliative care services at the right time for a patient who is at the last period of his/her life is this service's reason for being. According to the Directive, enabling the patients who are found eligible for palliative care to benefit from this opportunity “just because they need it” is an ethical responsibility.

*Article 15—(1-3) “The centers determine the palliative care patients residing within their service area by means of making use of the records that family practitioners and home care service units keep, and then create their own database. (...) It is obligatory to take the necessary security precautions in order to record separate files for each patient, to record register and follow-up books, to record data in computer environment and to protect them in the period and manner as specified in the legislation, and to share personal and statistical information of the patient.”*

**Protection of personal data:** in the Directive, protection of the personal data of the patients is deemed obligatory. Personal data comprise information about an individual's identity and also include information as to a patient's illnesses. The principle of non-maleficence to the confidentiality of the patients and their relatives entails respect for their private life. Members of the team providing palliative care services can share patients' personal or statistical data with the second or third parties or with the relevant institutions only to an extent that the patients permit. In the contrary cases, it can be stated that the individual's private life is not respected, and this means that respect for autonomy, which is one of the basic ethical principles, is violated. Therefore, such practices are ethically unacceptable.

## Sixth section

Patient Rights, Termination of Service, Training, Supervision and Responsibility

*Article 16—(1) “Patients accepted to palliative care services shall be informed about patient rights and liabilities and the content of the service. The patient himself or his legal representative has the right to receive all kinds of information about the service to be provided and the risks (if any). And, the patient has the right to refuse the service. Legislation provisions regarding patient rights are reserved.”*

**Informing the patient and the patient's volunteering:** it can be seen that the Directive respects persons and pays attention to patient autonomy. The patient's volunteering for admission to palliative care is regarded as a value in line with the principle of respect for patient's autonomy. The patient's volunteering is based on the information given to the patient as to the content of palliative care service. Therefore, in the Directive, a special attention was attached to informing the patient. The basic reason for emphasizing its importance is to ensure that the patient rights, which are part of human rights specific to the field of medicine, are reflected on medicine in practice. Otherwise, the patient's volunteering might be at risk, and the patient's autonomy might be damaged. Giving incomplete information to the patient about the end-of-life or his/her chronic diseases, pressuring the patient, and deceiving the patient about the possible benefits of palliative care might impair the patient's volunteering; therefore, such practices are ethically unacceptable. In the delivery of palliative care services, healthcare professionals are expected to ensure that patients receive a care service compatible with human dignity in the challenging conditions they face. Moreover, the patients' giving of consent for the palliative care to be offered to them is based on the information given to them and making sure that it was fully comprehended by them. At this stage, the content of the information to be given to the patients demanding palliative care or their relatives is important. The understanding of what palliative care constitutes the “informing” phase of the process. Also referred to as “getting informed consent,” the process is the reflection of the basic ethical principle of respect for autonomy on the field of medicine.

**Refusal to healthcare:** in line with the principle of respect for autonomy, healthcare professionals who provide palliative care services should understand it when a patient refuses to receive care service on his/her own consent. Therefore, they should neither force patients or their families to receive palliative care services nor put pressure on patients in order to persuade them. The most ethically appropriate approach would be letting the patients make their own decisions as to the healthcare services they will receive no matter how big their pain and suffering is.

*Article 17—1 (b) “In the event that the patient’s or his legal representatives demand termination of the service, or that the patient or his family members exhibit misbehavior and resist to comply with the recommendations, the beneficence of the service is questioned by the specialist physician in charge, and the decision regarding the termination of the service shall be made by means of negotiating with the patient and family members, and the decision shall be recorded with an official report.”*

**Terminating the care:** it cannot be claimed that palliative care fits for its purpose if the patient does not benefit from the provided service. According to the Directive, if no positive change is observed in respect of the patient’s quality of life, a decision to terminate the service shall be made. Such a decision cannot be made by the physician alone. In the Directive, it was pointed out that the patient or patient’s relatives should also be included in the decision-making process for termination of palliative care. Besides, if the patient claims that she/he has benefited from the treatment psychologically, though not physiologically, the physician’s termination of care service is not ethically appropriate. Palliative care can be terminated if patients or their relatives consider palliative care as unnecessary or there is strong evidence that the planned care does not make a positive contribution to the patient’s quality of life.

## 5. Conclusion

As well as the principles that it recognizes, medicine is also renowned for the practices that it deems unacceptable on ethical grounds. Practices such as overlooking the health needs of patients with chronic diseases or terminal patients and disregarding their healthcare needs, for instance, are ethically unacceptable.

The conditions that patients or their relatives face might sometimes hinder them from pursuing a quality life. If they prefer, they can receive palliative care, which can give them a chance to have a fairly quality life. Palliative care is crucial for maintaining the confidence in medicine and cannot be considered separately from the medicine’s duty to help.

In Turkey, how and by whom palliative care should be given to a patient approaching to the end of his/her life is determined by the relevant directive. Providing the service in line with the legislation and regarding patient rights, professional ethics, and medical deontology is essential. In palliative care centers, under the coordination of Provincial Directorate of Health, health services are provided in collaboration with local authorities, other health institutions in the region, universities, and with other related institutions. Besides, the centers also take the responsibility to contribute to the training of the society by means of planning trainings that go beyond the institution.

The fact that the Directive involves the doctrine of informed consent, which is the reflection of the principle of respect for autonomy on medical practices, illustrates the importance attached to patient rights in palliative care services. Nevertheless, there are still issues to be dealt with such as identifying the ethical dilemmas, which may emerge due to telling the patients and their relatives the truth, giving them the bad news, and decision-making for the end-of-life decisions, and taking measures in order to solve them. Ethical mistakes that healthcare professionals make out of ignorance might be eliminated if their knowledge on the issues not covered in the Directive is reinforced through in-service trainings.

Early identification and assessment of life-limiting diseases match up with the *raison d’être* of palliative care services. In this context, palliative care aims to support both the patients and their family members who encounter such problems when it comes to life-threatening diseases. In order to identify the ethical problems



seen in palliative care services in Turkey, qualitative and quantitative studies are needed to be carried out. As palliative care services become a more common practice in Turkey and more sophisticated solutions are offered as to the ethical problems encountered in practice, the structure of the palliative care service delivery will also go through transformation.

### **Conflict of interest**

The author declares that there is no conflict of interest regarding the publication of this article.

### **Other declarations**

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